

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008496

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318
FILED MAR 8 1963

Primary Registration District No.

1003

Registrar's No.

2194

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 912 Russell Blvd.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle CUJIC Last		4. DATE OF DEATH Month FEBRUARY Day 24 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/15/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Leeka, Yugoslavia	
13a. FATHER'S NAME Steven Cujic		13b. MOTHER'S MAIDEN NAME Martha Cujic	
15. WAS DECEASED EVER IN U.S. ARMED FOR (Yes, no, or unknown) (If yes, give war or date) no		17. INFORMANT Mildred Radovic 2317a Ann Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS, CLOSTRIDIUM WELCHII DUE TO (b) ACUTE TUBULAR NECROSIS KIDNEYS DUE TO (c) 60.2x Staghorn calculus		INTERVAL BETWEEN ONSET AND DEATH 10-12 Hrs. Sev. Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Staghorn calculus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
21. I attended the deceased from 2/24/63 to 2/24/63 and last saw her alive on 2/24/63 Death occurred at 10:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F. R. BRADLEY, M.D. <i>F.R. Bradley M.D.</i>		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 2/25/63		22d. NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/28/63	
24. FUNERAL DIRECTOR CHULICK UND. CO. 1722 S. Jefferson		25. DATE RECD. BY LOCAL REG. FEB 27 1963	
26. REGISTRAR'S SIGNATURE <i>Edna Smith M.D.</i>		27. LOCATION (City, town, or county) St. Louis County, Mo.	

USE BLACK INK
OR
TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed V.E. Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.